Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARCUS HAYES DC
PO BOX 198
BARKER TX 77413

Respondent Name
NORTH EAST INDEPENDENT SCHOOL

Carrier's Austin Representative Box
Box Number 55

MFDR Tracking Number
M4-11-4235-01

MFDR Date Received
JULY 19, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The IC's position, according to Dr. Fuentes letter, is that the FCE I performed was not medically necessary and therefore subject to pre-authorization. However, if it is the IC's opinion that the FCE was not medically necessary, the IC should have denied payment based on 'unnecessary medical' and provided the documentation supporting their position. Medical necessity is an entirely different argument. And while I disagree with Dr. Fuentes' opinion regarding the medical necessity of the evaluation, the issue remains the same: FCEs do not require preauthorization. FCEs, like other evaluations, are subject to retrospective medical necessity review, but not to preauthorization as defined by DWC Rule 134.600. In this particular case, The TDI-DWC MFG defines the number of FCEs allowed that can be performed per Rule 134.204(g): '…A maximum of three FCEs for each compensable injury shall be billed and reimbursed…'. Again, 'medical necessity of this particular evaluation can be argued, however, the fact still remains that FCE's do not require pre-authorization."

Amount in Dispute: $384.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier's position is • the FCE dated 05/24/11 performed by Marcus Hayes, DC, was subject to preauthorization to establish medical necessity per DWC Rule 134.600(p)(12): 'Non-emergency health care requiring preauthorization includes: (12) treatment and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols…' Official disability guidelines Forearm, Wrist, and Hand Chapter did not address FCE criteria and Official Disability Guidelines Fitness for Duty Chapter FCE is exceeded/not met; and • DWC Rule 134.204(g) is strictly a reimbursement guideline once medical necessity has been determined. Medical necessity must be established prior to apply this medical fee reimbursement guideline; The *Office Disability Guidelines* is adopted treatment guideline for Texas Workers' Compensation. Per CCH decision of 11/12/10, the IW sustained a 'right middle finger metacarpalphalangeal (sic) joint radial collateral injury'; therefore, the 'Forearm, Wrist, and Hand' Chapter of ODG would be applicable. This chapter does not address medical necessity for an FCE; therefore, the service was subject to preauthorization per DWC Rule 134.600(p)(12)."

Response Submitted by: Dr. Rosa A. Fuentes, MD, NEISD, 6961 Tesoro Drive, Ste. 410, San Antonio, TX 78217

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2011	CPT Code 97750-FC	$384.00	$384.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for obtaining preauthorization.
3. 28 Texas Administrative Code §134.204 sets out the guidelines for reimbursement of workers' compensation specific services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notifications absent.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Does the service in dispute require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the FCE for date of service May 24, 2011 using denial code 197 – Precertification/authorization/notifications absent", citing 28 Texas Administrative §134.600(p)(12), which states, "treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier"; the carrier further stated that "This chapter does not address medical necessity for an FCE; therefore, the service was subject to preauthorization per DWC Rule 134.600(p)(12)." According to 28 Texas Administrative Code §134.204(g), "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury **shall** be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test." Therefore, preauthorization is not required for this evaluation code.

   In accordance with 28 Texas Administrative Code §134.203(c)(1) reimbursement is as follows:

   - (54.54 ÷ 33.9764) x $30.34 x 8 units. The requestor is seeking $384.00.

2. Review of the submitted documentation finds that the FCE did not require preauthorization, for that reason the requestor is entitled to reimbursement for the service in dispute. As a result the amount ordered is $384.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $384.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $384.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 7, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

.